STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION (X1) PROVIDER OR SUPPLIER 445406 NAME OF PROVIDER OR SUPPLIER COMMUNITY CARE OF RUTHERFORD SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY PULL TAG FREGULATORY OR LSC IDENTIFYING INFORMATION) FREGULATORY OR LSC IDENTIFYING INFORMATION) FOR DURIng the annual Recertification survey conducted on June 6-8, 2011, at Community Care of Rutherford County, no deficiencies were cited in relation to complaints #27749 and #27528 under 42 CFR PART 482.13, Requirements for Long Term Care. F 281 SS=D FOR PRESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, laboratory log review, policy review, and interview, the facility failed to obtain a laboratory specimen as ordered by the physician for one resident (#4) of twenty-six residents reviewed. The findings' included: Resident #4 was admitted to the facility on March 23, 2011, with diagnoses including Persistent Vorniting, Late Effect Cardiovascular Accident, and Esophageal Reflux. Medical record review of the physician phone order dated April 22, 2011, revealed "3. T4 TSH (thyroid studies) in 2 weeks" A45406 STREET ADDRESS, CITY, STATE, ZIP CODE 901 COUNTY FARM RD MURREESBORD, TN 37127 MURREESBORD, TN 37127 This Plan of Correction (PCC) constitutes my writer allegation of compliance for the deficiencies cited. However, submission of this PCC is submitted to meet requirements for Long Term Care. F 281 This Plan of Correction (PCC) constitutes my writer allegation of compliance for the deficiencies were cited in relation to Long Term With English and PCC is submitted to meet requirements for Laboratory services. Setablished by state and federal law. F 281 This Plan of Correction (PCC) constitutes my writer allegation of compliance of the deficiencies were cited to now was cited correctly. This PCC is submitted to meet requirements for Laborat			LAND HUMAN SERVICES	15th	- M/23/1/	FORM): 06/10/201 A APPROVE): 0938-039
ANAME OF PROVIDER OR SUPPLIER COMMUNITY CARE OF RUTHERFORD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG FREEIX TAG INITIAL COMMENTS During the annual Recertification survey conducted on June 8-8, 2011, at Community Care or Rutherford County, no deficiencies were cited in relation to complaints # 27749 and #27529 under 42 CFR PART 482.13, Requirements for Long Term Care. F 281 483.20(k(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, laboratory log review, policy review, and interview, the facility failed to obtain a laboratory specimen as ordered by the physician for one resident (#4) of twenty-six residents reviewed. The findings' included: Resident #4 was admitted to the facility on the findings' included: Resident #4 was admitted to the facility on the facility of all the standard of the province of the facility on the facility of the physician for one resident (#4) of twenty-six residents reviewed. The findings' included: Resident #4 was admitted to the facility on the facility of all the facility of the physician for one resident (#4) of twenty-six residents reviewed. The findings' included: Resident #4 was admitted to the facility on the facility on the facility of the physician for one resident (#4) of twenty-six residents reviewed. The findings' included: Resident #4 was admitted to the facility on the facili	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	The Control of Control	1000		
COMMUNITY CARE OF RUTHERFORD SUMMARY STATEMENT OF DEFICIENCISS (EACH DEFICIENCY MUST BE PRECEDE BY PULL TAG FREETX TAG FOOD INITIAL COMMENTS During the annual Recertification survey conducted on June 6-8, 2011, at Community Care of Rutherford County, no deficiencies were cited in relation to complaints # 27749 and #27528 under 42 CFR PART 482.13, Requirements for Long Term Care 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, laboratory log review, policy review, and interview, the facility failed to obtain a laboratory specimen as ordered by the physician for one resident (#4) of twenty-six residents reviewed. The findings included: Medical record review of the physician phone order dated April 22, 2011, revealed "3. T4 TSH (thyroid studies) in 2 weeks." Both Community (EACH ORRECTIVE ACTION SHOULD BE PROFESSIONAL STANDARD) This Plan of Correction (POC) constitutes my written allegation of compliance for the deficiencies cited. However, submission of this POC is not an admission that a deficiency exists or that one was cited correctly. This POC is submitted to meet requirements established by state and federal law. The Facility will provide or arrange services that meet professional standards of quality related laboratory services. Resident # 4 66/11-Medical Doctor (MD) notified of status of May 1a bwill order for-synthroid to decreased to 250m/cg. Repeat T4 TSH in 2 weeks. 66/711 MD/RP notified or results of May lab with order for-synthroid to decreased to 250m/cg. Repeat T4 TSH in 2 weeks. 66/711 MD/RP notified or results of May lab with order for-synthroid to decrease to 250m/cg. Repeat T4 TSH in 2 weeks. 66/711 MD/RP notified or obtain a laboratory services. 66/711 MD/RP notified or service or will not of the professional standards of quality related to process for long of the professional standards of qua		*	445406				08/2011
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS During the annual Recertification survey conducted on June 6-8, 2011, at Community Care of Rutherford County, no deficiencies were cited in relation to complaints # 27749 and #27528 under 42 CFR PART 452. 13, Requirements for Long Term Care. F 281 483,20(k/3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, laboratory log review, policy review, and interview, the facility failed to obtain a laboratory specimen as ordered by the physician for one resident (#4) of twenty-six residents reviewed. The findings included: Medical record review of the physician phone order dated April 22, 2011, revealed "3. T4 TSH (thyroid studies) in 2 weeks" Medical record review of the physician phone order dated April 22, 2011, revealed "3. T4 TSH (thyroid studies) in 2 weeks" Medical record review of the physician phone order dated April 22, 2011, revealed "3. T4 TSH (thyroid studies) in 2 weeks"	NAME OF F	PROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CO	DE "	
FREEIX TAG FREGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS During the annual Recertification survey conducted on June 6-8, 2011, at Community Care of Rutherford County, no deficiencies were cited in relation to complaints # 27749 and #27528 under 42 CFR PART 482.13, Requirements for Long Term Care. F 281 483.20(k)(3)(f) SERTICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, laboratory log review, policy review, and interview, the facility failed to obtain a laboratory specimen as ordered by the physician for one resident (#4) of twenty-six residents reviewed. The findings included: Resident # 4 was admitted to the facility on March 23, 2011, with diagnoses including Persistent Vomiting, Late Effect Cardiovascular Accident, and Ecophageal Reflux. Medical record review of the physician phone order dated April 22, 2011, revealed "3, T4 TSH (thyroid studies) in 2 weeks. Birch Correction (POC) constitutes my written allegation of constitutes my written	COMMU	NITY CARE OF RUTH	ERFORD		**************************************		
During the annual Recertification survey conducted on June 6-8, 2011, at Community Care of Rutherford County, no deficiencies were cited in relation to complaints #27749 and #27528 under 42 CFR PART 482.13, Requirements for Long Term Care. F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, laboratory log review, policy review, and interview, the facility failed to obtain a laboratory specimen as ordered by the physician for one resident (#4) of twenty-six residents reviewed. The findings included: Resident #4 was admitted to the facility on March 23, 2011, with diagnoses including Persistent Vorniting, Late Effect Cardiovascular Accident, and Esophageal Reflux. Medical record review of the physician phone order dated April 22, 2011, revealed "3. T4 TSH (thyroid studies) in 2 weeks"	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION DATE
F 281 SS=D The Services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, laboratory log review, policy review, and interview, the facility failed to obtain a laboratory specimen as ordered by the physician for one resident (#4) of twenty-six residents reviewed. The findings included: Resident #4 was admitted to the facility on March 23, 2011, with diagnoses including Persistent Vomiting, Late Effect Cardiovascular Accident, and Esophageal Reflux. Medical record review of the physician phone order dated April 22, 2011, revealed "3. T4 TSH (thyroid studies) in 2 weeks" The Facility will provide or arrange services that meet professional standards of quality related laboratory services. Resident #4 6/6/11-Medical Doctor (MD) notified of status of My T4 TSH thyroid studies iab. 6/6/11 Nurse Managens (NM) conducted 100% audit of lab prefixed of results of May abwith order in-synthroid to be decreased to 250mcg. Repeat [T4 TSH In 2 weeks. 6/6/11 Nurse Managens (NM) conducted 100% audit of lab orders to ensure compliance for all lab orders in the event a NM is out of facility for an extended period of time, a Minimum Data Set nurse (MDS) will be the proxy. 6/7/11-Dlagnostic Testing Services Policy reviewed and revised by nursing management/MD with revision to require a second Licensed Nurse to review all MD orders and sign to validate timely and accurate transcription. 6/20/11/All Licensed Nurses (I.N) were in-serviced by interior of Nursing (DON) on Diagnostic Testing Services Policy related to process for logging monthly laboratory services. 6/13/11/Nurse Managers will audit 100% of telephone orders on a daily basis. Director of Nursing will ensure audits are conducted for on-going compliance. All findings will be forwarded to the QAA Committee (Quality Assessment Assurance Committee) for review and	F 000	During the annual conducted on June Care of Rutherford cited in relation to #27528 under 42 C	Recertification survey 6-8, 2011, at Community County, no deficiencies were complaints # 27749 and FR PART 482.13,	F 000	constitutes my written allegated compliance for the deficient of the defic	ation of cies cited. s POC is not noy exists or . This POC ements	
Medical record review revealed no laboratory data for thyroid studies in May 2011. Review of the May 2011, Laboratory Log revealed no documentation of resident's #4 thyroid studies. BORATORY DIRECTOR'S ON PROVIDER/SUPPLIER REPRESENTATIVE/SIGNATURE recommendations. Facility Administrator will ensure all findings and recommendations are evaluated during the facility's QAA meeting which will be conducted at least quarterly with attendees to include but not limited to the Medical Director,	SS=D	483.20(k)(3)(i) SER PROFESSIONAL S The services provide must meet professional services provided and the services provided and the services provided and the services are services are services and the services are ser	ed or arranged by the facility conal standards of quality. IT is not met as evidenced record review, laboratory log v, and interview, the facility coratory specimen as ordered one resident (#4) of reviewed. d: mitted to the facility on March oses including Persistent t Cardiovascular Accident, flux. w of the physician phone 2011, revealed "3, T4 TSH weeks" w revealed no laboratory es in May 2011. 011, Laboratory Log revealed resident's #4 thyroid studies.		meet professional standards of qualiaboratory services. Resident # 4 6/6/11-Medical Doctor (MD) notified May T4 TSH thyroid studies lab. 6/6/11 Lab performed – no change 6/7/11 MD/RP notified of results of order forr-synthroid to be decreased Repeat T4 TSH In 2 weeks. 6/6/11 Nurse Managers (NM) condi- audit of lab orders to ensure compil- orders. In the event a NM is out of extended period of time, a Minimum nurse (MDS) will be the proxy. 6/7/11MD notified and all lab studie and logged appropriately. 6/7/11-Diagnostic Testing Services reviewed and revised by nursing may with revision to require a second Lic to review all MD orders and sign to and accurate transcription. 6/20/11All Licensed Nurses (LN) we by Director of Nursing (DON) on Dia Testing Services Policy related to pu logging monthly laboratory services 6/13/11Nurse Managers will audit 10 telephone orders on a daily basis. Director of Nursing will ensure audit conducted for on-going compliance. will be forwarded to the QAA Comm Assessment Assurance Committee) recommendations. Facility Administ ensure all findings and recommenda- evaluated during the facility's QAA r will be conducted at least quarterly to include but not limited to the Med	d of status of in levels May lab with d to 250mcg. ucted 100% lance for all lab facility for an in Data Set is are updated Policy anagement/MD censed Nurse validate timely are in-serviced agnostic rocess for All findings hittee (Quality) for review and rator will ations are meeting which with attendees ical Director,	X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HNBV11

Facility ID: TN7504

If continuation sheet Page 1 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		445406	B. WING_			08/2011		
NAME OF PROVIDER OR SUPPLIER COMMUNITY CARE OF RUTHERFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 901 COUNTY FARM RD MURFREESBORO, TN 37127					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE ENCY)	(X5) COMPLETION DATE		
SS=D	Review of the facil Services revealed Lab order, the recoplacing the order in ordered and computerview on June conference room, (LPN) #2, confirmed the order Laboratory Log and obtained by the facility must enconfirmed the confirmed the confirmed the order Laboratory Log and obtained by the facility must encounter the facility must encounter the facility must encounter the facility failed to be properly secured during the facility failed to be properly secured during resident (#8) of	ity policy for Diagnostic Testing "Process3. Upon receipt of eiving nurse is responsible for nto the lab log for the month leting the requisition" 6, 2011, at 3:25 p.m., in the with Licensed Practical Nurse of LPN #2 received the April der. Further interview or was not on the May 2011 If the thyroid specimen was not allity. F ACCIDENT VISION/DEVICES asure that the resident has as free of accident hazards each resident receives on and assistance devices to IT is not met as evidenced record review, review of the on, observation, and interview, ensure a wheel chair was ring van transportation for twenty-six residents to secure one of one	F 323		resident environment t hazards as is possible adequate supervision prevent accidents ed to 6/2/11 incident. a non-related medical us was assessed by tional Therapy to or long-based chairs & electric meelchairs was of wheelchair, the bus to ensure secure ation. ponsible for transport in-serviced by staff is transportation with d. Policy is posted on book and by the bus. or and Bus Driver are ement of policy to the for transportation. ctor will conduct thus at least weekly to			
•	11 .			placed in bus and secured.	a ere appropriately			

FORM CMS-2567(02-99) Previous Versions-Obsolete - Event ID: HNBV11

Facility ID: TN7504

If continuation sheet Page 2 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII B. WING	50 San 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	(X3) DATE COMPI	
NAME OF	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STAT		99/2011
COMMUNITY CARE OF RUTHERFORD			1	901 COUNTY FARM RD MURFREESBORO, TN	0.00 .1 000.44	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
	Resident #8 was a February 2, 2011, Transverse Myelitin Hypertension, Obe Medical record revidated March 4, 20 impairment on both Review of the facility information dated Jackston and the frevealed the facility wheelchair prior to Interview with the injune 7, 2011, at 10 nurses' station, con all wheels on the wicausing the resident Continued interview Nursing revealed the local emergency noted. Further interview revealed the incidents. Resident #25 was a 12, 2011, with a diarecord review of the up-dated on June 1, wandered on the un rooms and was residenced. Survival of the up-dated on June 1, wandered on June 1, wand	dmitted to the facility on with diagnoses including Acute is to Lower Extremities, sity, and Cellulites of Leg. Iew of the Minimum Data Set 11, revealed the resident had in sides of the lower extremities. Ity's fall investigation lune 2, 2011, revealed the rin the wheelchair while being acility's van. Continued review failed to lock all wheels on the transporting. Interim Director of Nursing on 100 a.m., at the H-wing firmed the facility failed to lock neelchair prior to transporting to tip over in the van. I with the interim Director of e facility sent the resident to room, no conclusive fracture view and medical record resident had no further I dmitted to the facility on May gnosis of Dementia. Medical resident's current care plan 2011, revealed the resident it and into other resident	F 323	Resident #25 Resident was within five (treatment cart before the to secured/locked the trea 6/6/11- MSDS sheet was medication in the cart for reference. 6/16-6/20/11- DON in-sen Nurses regarding current treatment cart to be locked nurse is not in attendance 6/13/11 Sign placed on a "LOCK BEFORE LEAVING 6/13/11 LN will check trea change of shift to ensure i 6/13/11 NM will conduct re treatment carts between in ensure they are locked in NM will ensure treatment of audits are conducted for o All findings will be forward Committee (Quality Asses Committee) for review and Facility Administrator will e recommendations are eva facility's QAA meeting while least quarterly with attende limited to the Medical Direct Worker, Activity Director, O Maneger, Maintenence and Director.	licensed nurse returned itment cart. secured for each staff education and viced all Licensed policy requiring the d at all times when the cart to remind nurses to G". Itment cart during the secured/locked. andom audits of locurs of 7A-11 PM to accordance with policy. cart observation in-going compliance, ed to the QAA sment Assurance if recommendations. It include but not cort, DON, NHA, Social certified Dietary	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HNBV11

Facility ID: TN7504

If continuation sheet Page 3 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/10/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILE	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
NAME OF I	PROVIDER OR SUPPLIER	445406	Щ,		DRESS, CITY, STATE, ZIP CO		08/2011
COMMUNITY CARE OF RUTHERFORD				901 COL	INTY FARM RD EESBORO, TN 37127	JUE	
(X4) ID PREFIX TAG	(EACH DÉFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	С	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 425 SS=D	the hallway. Contresident #25 was unsupervised, worresident was not or drawers. Continue p.m., the wound treatment cart. Review of the investment cart prowarning labels of "children" included: dressings adhere sanitizer; zinc oxid skin); Bactroban (acream (hormonal cantifungal); Nystal irritated skin); Bazaskin); Equate Athlemuscles); Freezit (spray (warning to respray); Happy Hine Hydrogen Peroxide Swabsticks (cleans ointment (antibiotic Interview on June 7 wound treatment nutreatment cart was the contents of the easily accepsed. 483.60(a),(b) PHAFACCURATE PROC	inued observation revealed within five feet of the unlocked, and treatment cart. The observed to attempt to open the ed observation revealed at 4:35 eatment nurse arrived at the intory list of the contents of the vided by the facility that had keep out of the reach of Prep Site (used to help to skin); alcohol based hand e (cream used for irritated antibiotic ointment); Premarin cream); Nystatin powder tin and Triamcinolone (to treat a cream (used to treat irritated ete's foot; Muscle Rub (for sore for sore muscles); Granulex tot spray into eyes or inhale ety Ointment; Isopropyl Alcohol; et wounds); povidone iodine et wounds); and Bacitracin b. 7, 2011, at 4:35 p.m., with the urse confirmed the wound unlocked, unsupervised, and drawers could have been	F 32	The fac docume	ility will ensure the pharmacy nts the physician orders on t lation orders each month		

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Event ID: HNBV11

Facility ID: TN7504

If continuation sheet Page 4 of 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/10/2011 FORM APPROVED

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI B. WING		(X3) DATE S COMPL	ETED
		445406			06/0	08/2011
5-0-312034-01/250A()	PROVIDER OR SUPPLIER			FREET ADDRESS, CITY, STATE, ZIP COL 901 COUNTY FARM RD MURFREESBORO, TN 37127	ישׁי	
(X4) ID. PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	\$483.75(h) of this unlicensed person law permits, but or supervision of a lid. A facility must prov. (including procedu acquiring, receiving administering of all the needs of each. The facility must era licensed pharma on all aspects of the services in the facility. Based on medical and interview the fapharmacy accurate orders on the month two (#5, #7) of twenth of the findings include Resident #5 was ad November 18, 2008 11, 2011, with diagr. Mellitus, and Percut Gastrostomy.	reement described in part. The facility may permit nel to administer drugs if State nly under the general sensed nurse. Vide pharmaceutical services res that assure the accurate g, dispensing, and I drugs and biologicals) to meet resident. Imploy or obtain the services of cist who provides consultation e provision of pharmacy lity. NT is not met as evidenced record review, observation, cility failed to ensure the ly documented the physician nly recapitulation orders for aty-six residents reviewed. In itted to the facility on and readmitted on March access including Diabetes raneous Endoscope	F 425	Resident # 5. MD ordered/intended to have Gluce tube feeding formula at 75cc/hour. Resident was receiving Glucerna 1.1 feeding formula at 75cc/hr. There was loss. 6/7-8/11- Pharmacy notified by Certi Manager (CDM) and Nursing Home (NHA) of transcription error related to formula. Monthly Physician Recapul and MAR was corrected to reflect comatch the tube feeding formula bein tube. Resident # 7 MD ordered/intended to have Glucer calories at 85cc/hour. Resident was receiving Glucerna 1.5 feeding formula at 85cc/hour. 6/7-8/11 - Pharmacy notified by CDM transcription error related to feeding Monthly Physician Recapulation order was corrected to reflect correct order tube feeding formula being delivered 6/10/11 - Nurse Manager conducted residents receiving nutrition via tube ensure 100% compliance for MD orders/transcription accuracy/printed Physician Order and MAR accuracy. 6/10/11-Policy developed requiring tw signatures/review to ensure accuracy transcription of physician orders and "change over" orders to ensure all ME transcribed correctly from the original Recapulation Physician Order and M/6/20/11 DON conducted all Licensed Nurse In-service related to new Policy Checking Physician Orders to include "change over" orders. By the 15th each month the Medical Finurses will audit 20% of the active mercords for transcription accuracy. DON will ensure MD order audits are for on-going compliance. All findings will be forwarded to the Q/Committee (Quality Assessment Assu Committee) for review and recommend accuracy which will be commendations are evaluated durin facility's QAA meeting which will be commendations are evaluated durin facility's QAA meeting which will be commendations are evaluated durin facility's QAA meeting which will be commendations are evaluated durin facility's QAA meeting which will be commendations are evaluated durin facility and the process of the active will ensure all fire commendations are evaluated durin facility's QAA meeting which will be commendations are evaluated durin facili	5 calorie tube as no weight iffed Dietary Administrator to feeding lation order order to get delivered via ma 1.5 5 calone tube M and NHA of formula er and MAR of to match the livia tube. 100% audit of feeding to Recapulation wo (2) nursing yin monthly Diorders are lorder to the AR or to match the lorder to the AR or to monthly condens are lorder to the AR or to monthly Records edical conducted AA utrance redetions andings and ing the	

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Event ID: HNBV11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445406		(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED - 06/08/2011			
NAME OF PROVIDER OR SUPPLIER COMMUNITY CARE OF RUTHERFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 901 COUNTY FARM RD				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH, CORRECTIVE ACTION SHOULD BE			
F 425	(calorie) (tube feed milliliters (ml) per I record review of the Order revealed "	ding formula for diabetics) at 75 nour for 16 hours" Medical te April 2011, Recapitulation Glytrol Enteralfor Glucerna	F 425	least quarterly with attendees to limited to the Medical Director, I Worker, Activity Director, Certifi Manager, Maintenance and Hoo Director.	DON, NHA, Social ed Dietary		
	centimeters per ho record review of th	give 75 cc/hr (cubic our) for 16 hour" Medical e May and June 2011, ers revealed "Glytrolgive		2 0 E	3		
	1:24 p.m., in the re bottle of Glucerna identifying the pum observation reveals	ne 7, 2011, at 7:40 a.m. and sident's room, revealed a 1.5 calorie with the label p rate of 75 cc/hr. Further ed the pump rate was set at					
	the conference roo p.m., confirmed the	nterim Director of Nursing, in m, on June 7, 2011, at 2:05 facility had administered		1 × 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	zi		
	readmission and the correctly identify the	the March 11, 2011, e pharmacy had failed to e tube feeding formula, ne April, May and June 2011, ers.					
	September 8, 2010, on May 4, 2011, wit	Imitted to the facility on and readmitted to the facility h diagnoses including nd Percutaneous Endoscope				9	
	order dated May 5, ; (discontinue) Glucel diabetics) 1.5 (calor	ew of the physician phone 2011, revealed "D/C rna (tube feeding formula for ies) @ (at) 65 ml/hr (milliliters cerna 1.2 (calories) @ 85				*	

FORM CMS-2567(02-99) Previous Versions Obsolete - . . .

Event ID: HNBV11

Facility ID: TN7504

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES.

PRINTED: 06/10/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445406		A, BUILDING B. WING		(X3) DATE S COMPLI	ETED			
	ROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 901 COUNTY FARM RD MURFREESBORO, TN 37127					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 425	Recapitulation O June 2, 2011, revector (cubic cention on J 1:43 p.m., and J 9:58 a.m., in the bottle of Glucernathe pump rate at revealed the pum Interview with Lic June 7, 2011, at confirmed the tub Glucerna 1,2 at a	eview of the June 2011, rder, signed by the physician on realed "Glucema 1.2 @ 65 imeters per hour) x 22 hr" June 6, 2011, at 10:31 a.m. and une 7, 2011, at 7:47 a.m. and resident's room, revealed a a 1.2 with the label identifying 85 cc/hr. Further observation hp was set at 85 cc/hr. ensed Practical Nurse #1, on 9:58 a.m., in the resident's room, he feeding administered was urate of 85 cc/hr. Further	F 425					
	was Glucerna 1.2 Interview with the June 7, 2011, at 2 room, confirmed tidentify the tube for May 5, 2011, pho Recapitulation Or	interim Director of Nursing, on 2:05 p.m., in the conference the pharmacy failed to correctly eeding rate of 85 cc/hr per the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: HNBV11

Facility ID: TN7504

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